

EXHIBIT A

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

SOUTHEAST MICHIGAN SURGICAL
HOSPITAL, LLC, SPINE PLLC, SUMMIT
MEDICAL GROUP, PLLC, SUMMIT
PHYSICIANS GROUP, PLLC, GETTER
DONE TRANSPORTATION, LLC,
and KEVIN T. CRAWFORD, DO, PC,

Case No. 18-014385-CK
Hon: John H. Gillis

Plaintiffs,

vs.

MAURICE LITTLE,

Defendant.

PAUL J. WHITING III (P61570)
STEVEN M. BRAUN (P79461)
WHITING LAW
Attorneys for Plaintiff
26300 Northwestern Hwy, Ste. 301
Southfield, MI 48076
(248)355-5900/(248)355-5901
steven.braun@844whiting.com
paul.whiting@844whiting.com

PLAINTIFFS' SECOND AMENDED COMPLAINT

NOW COMES Plaintiffs, SOUTHEAST MICHIGAN SURGICAL HOSPITAL, LLC, SPINE PLLC, SUMMIT MEDICAL GROUP, PLLC, SUMMIT PHYSICIANS GROUP, PLLC, GETTER DONE TRANSPORTATION, LLC, KEVIN T. CRAWFORD DO, PC, (hereinafter collectively "Plaintiffs") by and through their attorneys, WHITING LAW, and for their Complaint against Defendant, MAURICE LITTLE, state as follows:

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

JURISDICTIONAL ALLEGATIONS

1. Plaintiff, Southeast Michigan Surgical Hospital, LLC (hereinafter “SEMSH”), is a Michigan limited liability corporation, doing business in the County of Macomb, State of Michigan.

2. Plaintiff, Spine PLLC (hereinafter “Spine”), is a Michigan professional limited liability corporation, doing business in the County of Oakland, State of Michigan.

3. Plaintiff, Summit Medical Group, PLLC (hereinafter “SMG”), is a Michigan professional limited liability corporation, doing business in the County of Wayne, State of Michigan.

4. Plaintiff, Summit Physicians Group, PLLC (hereinafter “SPG”), is a Michigan professional limited liability corporation, doing business in the County of Wayne, State of Michigan.

5. Plaintiff, Getter Done Transportation, LLC (hereinafter “GTD”), is a Michigan limited liability corporation, doing business in the County of Oakland, State of Michigan.

6. Plaintiff, Kevin T. Crawford, DO, PC (hereinafter “CRAWFORD”), is a Michigan professional corporation, doing business in the County of Wayne, State of Michigan.

7. Defendant, Maurice Little (hereinafter “Defendant”) is believed to be a resident of the City of Davenport, County of Scott, State of Iowa.

8. Plaintiffs Southeast Michigan Surgical Hospital, LLC, Spine PLLC, Summit Medical Group, PLLC, Summit Physicians Group, PLLC, and Dr. Kevin T. Crawford, DO, PC are health care providers who provided care, treatment, and/or services to Defendant.

9. Furthermore, Plaintiff Getter Done Transportation, LLC, is a transportation provider who provided medical transportation to Defendant.

10. That the amount in controversy is in excess of Twenty-Five Thousand Dollars (\$25,000.00) and within the jurisdiction of this Court.

GENERAL ALLEGATIONS

11. Plaintiffs reincorporate and reallege paragraphs 1 through 10 as if fully set forth herein.

12. That on or about October 2, 2015, Defendant was involved in a serious motor vehicle accident wherein he sustained injuries that required medical care from Plaintiffs.

13. That as a result of that motor vehicle accident Defendant became entitled to Michigan No Fault benefits to pay for his care, recovery and rehabilitation.

14. That Non-Party Farm Bureau was the insurance company to pay for Defendant's medical care arising out of said motor vehicle accident.

15. That Non-Party Farm Bureau refused to pay for Defendant's No-Fault benefits necessitating Defendant to file a lawsuit against Non-Party Farm Bureau.

16. That on the eve of trial in that matter, Defendant and Non-Party Farm Bureau settled the claim with Non-Party Farm Bureau agreeing to defend and indemnify Defendant from Plaintiffs claims (*Exhibit 1 — Release Executed by Defendant*):

IT IS FURTHER EXPRESSLY AGREED that Farm Bureau will defend and indemnify **Maurice Little** from any and all claims, judgments, and liens asserted against **Maurice Little** by any healthcare or other medical provider, or any other person or entity, including but not limited to, Medicare and/or Medicaid, the Centers for Medicare and Medicaid Services, and the Medicare or Medicaid Secondary Payer Contractors and/or their agents, affiliates, or assignees, for any unpaid bills, invoices, or expenses of any type emanating from the injuries and claims made by **Maurice Little** in connection with the aforementioned accident and that were or could have been brought in the above referenced lawsuit.

17. That there is no dispute that Plaintiffs provided the claimed services to Defendant and that these services were for his care, recovery and rehabilitation resulting from injuries he

suffered in the motor vehicle accident. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

18. That there is no dispute that Defendant received and acknowledges liability for each of Plaintiffs' attached bills. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18 and Exhibits 3A through 3F — Billing Statements of Plaintiffs*).

19. That Non-Party Farm Bureau is aware of Plaintiffs bills and has refused to pay said bills.

20. That Defendant has not paid any of the incurred bills from any Plaintiff.

COUNT I –
PLAINTIFF SEMSH CLAIM AGAINST DEFENDANT

21. Plaintiff "SEMSH" reincorporates and realleges paragraphs 1 through 20 as if fully set forth herein.

22. Plaintiff "SEMSH" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

23. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

24. That Plaintiff "SEMSH" has incurred \$544,369.64 in medical bills for services rendered to Defendant. (*Exhibit 3A — Billing Statement of SEMSH*).

25. That Defendant has failed to pay Plaintiff "SEMSH" for the services it rendered.

26. That Plaintiff "SEMSH" is entitled to a judgement against Defendant in the amount of \$544,369.64, plus interest and attorney fees. (*Exhibit 3A — Billing Statement of SEMSH*).

COUNT II –
PLAINTIFF SPINE CLAIM AGAINST DEFENDANT

27. Plaintiff “SPINE” reincorporates and realleges paragraphs 1 through 26 as if fully set forth herein.

28. Plaintiff “SPINE” rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

29. That the services rendered by Plaintiff were reasonably necessary for Defendant’s care, recovery or rehabilitation.

30. That Plaintiff “SPINE” has incurred \$372,904.00 in medical bills for services rendered to Defendant. (*Exhibit 3B — Billing Statement of SPINE*).

31. That Defendant has failed to pay Plaintiff “SPINE” for the services it rendered.

32. That Plaintiff “SPINE” is entitled to a judgement against Defendant in the amount of \$372,904.00, plus interest and attorney fees. (*Exhibit 3B — Billing Statement of SPINE*).

COUNT III –
PLAINTIFF SMG CLAIM AGAINST DEFENDANT

33. Plaintiff “SMG” reincorporates and realleges paragraphs 1 through 32 as if fully set forth herein.

34. Plaintiff “SMG” rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

35. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

36. That Plaintiff "SMG" has incurred \$270.00 in medical bills for services rendered to Defendant. (*Exhibit 3C — Billing Statement of SMG*).

37. That Defendant has failed to pay Plaintiff "SMG" for the services it rendered.

38. That Plaintiff "SMG" is entitled to a judgement against Defendant in the amount of \$270.00, plus interest and attorney fees. (*Exhibit 3C — Billing Statement of SMG*).

COUNT IV –
PLAINTIFF SPG CLAIM AGAINST DEFENDANT

39. Plaintiff "SPG" reincorporates and realleges paragraphs 1 through 38 as if fully set forth herein.

40. Plaintiff "SPG" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

41. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

42. That Plaintiff "SPG" has incurred \$138,306.50 in medical bills for services rendered to Defendant. (*Exhibit 3D — Billing Statement of SPG*).

43. That Defendant has failed to pay Plaintiff "SPG" for the services it rendered.

44. That Plaintiff "SPG" is entitled to a judgement against Defendant in the amount of \$138,306.50, plus interest and attorney fees. (*Exhibit 3D — Billing Statement of SPG*).

COUNT V –
PLAINTIFF GTD CLAIM AGAINST DEFENDANT

45. Plaintiff “GTD” reincorporates and realleges paragraphs 1 through 44 as if fully set forth herein.

46. Plaintiff “GTD” provided transportation services to Defendant and for which Defendant acknowledges the need for transportation was the direct result of his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

47. That the services rendered by Plaintiff were reasonably necessary for Defendant’s care, recovery or rehabilitation.

48. That Plaintiff “GTD” has incurred \$\$7,455.00 in transportation bills for services rendered to Defendant. (*Exhibit 3E — Billing Statement of GTD*).

49. That Defendant has failed to pay Plaintiff “GTD” for the services it rendered.

50. That Plaintiff “GTD” is entitled to a judgement against Defendant in the amount of \$7,455.00, plus interest and attorney fees. (*Exhibit 3E — Billing Statement of GTD*).

COUNT IV –
PLAINTIFF CRAWFORD CLAIM AGAINST DEFENDANT

51. Plaintiff “CRAWFORD” reincorporates and realleges paragraphs 1 through 50 as if fully set forth herein.

52. Plaintiff “CRAWFORD” rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (*Exhibit 2 — Affidavit of Maurice Little Signed 4/20/18*).

53. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

54. That Plaintiff "CRAWFORD" has incurred \$12,566.00 in medical bills for services rendered to Defendant. (*Exhibit 3F — Billing Statement of CRAWFORD*).

55. That Defendant has failed to pay Plaintiff "CRAWFORD" for the services it rendered.

56. That Plaintiff "CRAWFORD" is entitled to a judgement against Defendant in the amount of \$12,566.00 plus interest and attorney fees. (*Exhibit 3F — Billing Statement of CRAWFORD*).

WHEREFORE, Plaintiffs pray for a Judgment against the Defendant, for the medical expenses that have been incurred, as applicable, in an amount in excess of **\$1,075,871.14**, together with costs and attorney fees so wrongfully sustained and interest to the date of judgment.

Respectfully Submitted,



PAUL J. WHITING III (P61570)
STEVEN M. BRAUN (P79461)
Attorneys for Plaintiff
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Southfield, MI 48076
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steven.braun@844whiting.com

Dated: November 8, 2018

Exhibit 1

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

SETTLEMENT AGREEMENT AND RELEASE

IT BEING THE INTENT of the parties hereto that certain claims for No-Fault Benefits be fully and finally resolved by this instrument, the claimant, **Maurice Little**, subscribes as follows:

I, **Maurice Little**, for the sole consideration of **THIRTY-FIVE THOUSAND AND 00/100 (\$35,000.00) DOLLARS**, to me in hand paid, receipt of which is hereby acknowledged do hereby for myself and for my heirs, executors, administrators, and assigns, release, acquit, and forever discharge FARM BUREAU INSURANCE COMPANY (hereinafter "Farm Bureau"), its officers, employees, agents, or lawyers, from all claims, damages, demands, or causes of action, incurred by or on behalf of **Maurice Little**, including but not limited to:

1. All claims for past, present, and future allowable expenses incurred because of the subject accident, which occurred on February 14, 2015, and is the subject of *Maurice Little v Farm Bureau*, Case No. 16-001973-NF, in the Wayne County Circuit Court;
2. All claims for past, present, and future Wage Loss incurred because of the subject accident, which occurred on February 14, 2015;
2. All claims for past, present, and future Household Replacement Services incurred because of the subject accident, which occurred on February 14, 2015;
3. All claims for past, present, and future Attendant Care Services incurred because of the subject accident, which occurred on February 14, 2015;
4. All claims for past, present, and future medical expenses incurred because of the subject accident, which occurred on February 14, 2015;
5. Any and all interest charges as provided under the No-Fault Statute (MCL 500.3101, et seq.);
6. Any and all interest charges as provided by the Revised Judicature Act, MCL 600.101, et seq.; and
7. Any and all reasonable attorney fees that may be owed to the attorneys for **Maurice Little** as provided by the No-Fault Statute, MCL 500.3101, et seq., as a consequence of the representation of **Maurice Little**;

I have represented that the injuries sustained are permanent and progressive, and that recovery therefrom is uncertain and indefinite, and in making this Settlement Agreement and Release, it is understood and agreed that I rely wholly upon my own judgment, belief, and knowledge of the nature, extent, and duration of said injuries and damages and that no representations or statements regarding said injuries and damages or regarding any other matters made by the persons, firms, or corporations who are hereby released, or any person or persons representing them or by any physician or surgeon by them employed, has influenced me to any extent whatsoever in making this Release.

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IT IS FURTHER EXPRESSLY AGREED that Farm Bureau will defend and indemnify **Maurice Little** from any and all claims, judgments, and liens asserted against **Maurice Little** by any healthcare or other medical provider, or any other person or entity, including but not limited to, Medicare and/or Medicaid, the Centers for Medicare and Medicaid Services, and the Medicare or Medicaid Secondary Payer Contractors and/or their agents, affiliates, or assignees, for any unpaid bills, invoices, or expenses of any type emanating from the injuries and claims made by **Maurice Little** in connection with the aforementioned accident and that were or could have been brought in the above referenced lawsuit.

IT IS FURTHER UNDERSTOOD that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

IT IS AGREED that this settlement is a compromise of a doubtful and disputed claim or claims and that any payment or payments made hereunder are not to be construed as an admission of liability or indebtedness on the part of Farm Bureau, by whom all liability or indebtedness is expressly denied. No terms or conditions contained with any check or draft tendered in satisfaction hereof shall modify, alter or expand the terms and conditions of this Release.

IT IS FURTHER AGREED that if any medical provider with whom I sought treatment in connection with the above-referenced accident files suit against **Maurice Little**, he will waive any potential conflict of interest and will allow Farm Bureau to appoint counsel of its choosing to represent him, and will fully cooperate with that counsel and actively participate in defense of the action(s).

IT IS FURTHER AGREED that **Maurice Little** will sign an authorization allowing Farm Bureau, its employees, and attorneys, to publicly discuss his case and to release to others all documents related to his case, including but not limited to medical records and deposition transcripts.

All agreements and understandings between the parties hereto are embodied and expressed herein and the terms of this Settlement Agreement and Release are contractual and not a mere recital. **I HAVE READ THE FOREGOING SETTLEMENT AGREEMENT AND RELEASE AND FULLY UNDERSTAND IT.**

The terms of this release and settlement shall remain private and confidential, and shall not be disclosed to individuals or entities, other than agents or representatives of the parties hereto, without prior authorization from Farm Bureau.

IN WITNESS HEREOF, I have set my hand and seal this 20th day of April, 2018.

IN THE PRESENCE OF:

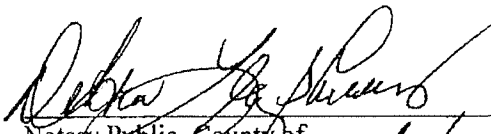
Melvin D. McNamee

WITNESS

Maurice Little
MAURICE LITTLE

Subscribed and sworn to before me this 20th day of April, 2018.

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Notary Public, County of _____
My Commission Expires: 2/7/2024

DEBRA LEAPHEART
Notary Public, State of Michigan
County of Wayne
My Commission Expires 02-07-2024
Acting in the County of Wayne

{2002755 }

Exhibit 2

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AFFIDAVIT OF MAURICE LITTLE

I, Maurice Little, hereby state and affirm the following to be true under the penalty of perjury:

1. On February 14, 2015, I was a restrained rear seat passenger traveling on I-94 when we were rear-ended by a semi-truck totaling the vehicle.
2. That as a result of said motor vehicle accident I suffered injuries to my neck, back, shoulder, hip and other areas throughout my body that required medical treatment.
3. That for these injuries I sought medical treatment from the following medical facilities and/or medical providers:
 - a. St. Joseph Mercy Hospital;
 - b. Dr. Kevin Crawford;
 - c. Dr. Jankowski;
 - d. Summit Medical Group and its physicians;
 - e. Summit Physicians Group, PLLC;
 - f. ORA Orthopedics;
 - g. Anesthesia Associations of Ann Arbor;
 - h. Oakwood Healthcare Group;
 - i. Drs. Harris, Birkhill, PC;
 - j. Getter Done Medical Transportation;
 - k. Auto RX;
 - l. Detroit Bio Medical Laboratories;
 - m. Radeas LLC;
 - n. Expertus Laboratories, Inc.;
 - o. Lab Geeks, LLC;
 - p. Geriatric Care Associates, PLLC.;
 - q. Mainwaring Pathology Group, PC.;
 - r. Guardian Anesthesia Services, LLC.;
 - s. Oakwood Annapolis Hospital;
 - t. Oakwood Ambulatory, LLC;
 - u. Regents of University of Michigan;
 - v. OHI Physician Network;
 - w. University of Michigan Health System;
 - x. Spine PLLC and Dr. Jeffery Wingate;
 - y. Southeast Michigan Surgical Hospital;
4. That both Medicare and Medicaid have paid medical expenses that were incurred as a result of medical treatment related to the injuries I sustained in the motor vehicle accident.

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5. That the medical treatment I received for my neck, back, shoulder, knee and hip, including but not limited to diagnostic testing, medication, injections, multiple surgeries, physical therapy, etc., were related to and necessary for my care, recovery and rehabilitation for injuries arising out of the motor vehicle accident.
6. That I acknowledge I received medical bills from each of the medical providers enumerated in paragraph #3 above.
7. That I acknowledge that I incurred all of the medical treatment provided by each medical provider enumerated in paragraph #3 above.
8. That I do not contest that I am solely responsible for payment of all the medical treatment provided by each of the medical providers enumerated in paragraph #3.
9. That I acknowledge that I testified in the matter of Maurice Little v. Farm Bureau and affirm that my testimony was and remains true and accurate.

I, Maurice Little, hereby swear and attest that the above is true and accurate.

Maurice Little 4-20-18
Maurice Little Date

Exhibit 3A

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UB-01 CMS-1450

Exhibit 3B

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MEDICARE
P O BOX 5533
MARION IL 62959

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input checked="" type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (TRICARE) CHAMPVA <input type="checkbox"/> (CHAMPVA) GROUP HEALTH PLAN <input type="checkbox"/> (Group Health Plan) FECA <input type="checkbox"/> (FECA) OTHER <input type="checkbox"/> (Other)		16. INSURED'S I.D. NUMBER (For Program in Item 1) 374723080A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L		3. PATIENT'S BIRTH DATE MM DD YY 08151964 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) LITTLE, MAURICE, L		5. PATIENT'S ADDRESS (No., Street) 1459 ANDREA STREET	
6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1459 ANDREA STREET	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER ADJ: SHERRIL KRAUSMAN	
12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either in myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) 02142015 QUAL		15. OTHER DATE (MM/DD/YY) 1134329493	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY 10052016 18052000		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY 10052016 18052000	
18. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		19. RESUBMISSION CODE ORIGINAL REF. NO.	
20. PRIOR AUTHORIZATION NUMBER		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (342) ICD Inc. 0	
22. A. DATE(S) OF SERVICE From To PLACE OF SERVICE MM DD YY MM DD YY L3 L4 10052016 10052016 21 22633 AB 18477 00 1 NPI 1235117524		23. B. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER L2 10052016 10052016 21 63005 59 AB 18200 00 1 NPI 1235117524	
24. C. DATE(S) OF SERVICE From To PLACE OF SERVICE MM DD YY MM DD YY L3 10052016 10052016 21 63047 AB 18052 00 1 NPI 1235117524		25. D. DATE(S) OF SERVICE From To PLACE OF SERVICE MM DD YY MM DD YY L5 S1 10052016 10052016 21 63042 59 AB 26064 00 2 NPI 1235117524	
26. E. DATE(S) OF SERVICE From To PLACE OF SERVICE MM DD YY MM DD YY L5 S1 10052016 10052016 21 22612 AB 15948 00 1 NPI 1235117524		27. F. DATE(S) OF SERVICE From To PLACE OF SERVICE MM DD YY MM DD YY 10052016 10052016 21 22842 AB 7740 00 1 NPI 1235117524	
28. FEDERAL TAX I.D. NUMBER SSN EIN 462343653 <input checked="" type="checkbox"/> X L4111		29. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JEFFREY K WINGATE SIGNATURE ON FILE		31. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP SPINE PLLC 21230 DEQUINDRE ROAD WARREN MI 48091-2279	
32. BILLING PROVIDER INFO & PH # (248 566 3313)		33. TOTAL CHARGE \$ 104481 00 \$ 0 00	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR051853

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



MEDICARE
P O BOX 5533
MARION IL 62959

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 374723080A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L		3. PATIENT'S BIRTH DATE 08151964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) 1459 ANDREA STREET		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY YPSILANTI STATE MI		CITY YPSILANTI STATE MI	
ZIP CODE 48198		ZIP CODE 48198	
TELEPHONE (Include Area Code) (313) 718 4781		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) LITTLE, MAURICE, L		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH 08151964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 02142015 QUAL		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JEFFREY K WINGATE		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 10052016 TC	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to services line below (24E) A. M5416 a. M5126 c. d. e. f. g. h. i. j. k. l.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS E. S CHARGES F. DAYS OR UNITS G. ICD-9-CM H. ICD-9-CM I. QUAL J. RENDERING PROVIDER ID #		23. PRIOR AUTHORIZATION NUMBER	
10052016 10052016 21 22851 AB 4149 00 1 NPI 1235117524			
L4 10052016 10052016 21 63048 AB 4320 00 1 NPI 1235117524			
10052016 10052016 21 38220 59 A 1485 00 1 NPI 1235117524			
10052016 10052016 21 20936 A 1450 00 1 NPI 1235117524			
10052016 10052016 21 20930 A 1100 00 1 NPI 1235117524			
10052016 10052016 21 76000 26 AB 80 00 1 NPI 1235117524			
25. FEDERAL TAX I.D. NUMBER SSN EIN 462343653 <input type="checkbox"/> <input checked="" type="checkbox"/> X		26. TOTAL CHARGE \$ 12584 00	
29. PATIENT'S ACCOUNT NO. L4111		28. AMOUNT PAID \$ 0 00	
27. ACCEPT ASSIGNMENT? (For gov. plans, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		30. Rev'd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JEFFREY K WINGATE SIGNATURE ON FILE SIGNED 10182016 a. 1750501938		32. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP SPINE PLLC 21230 DEQUINDRE ROAD WARREN MI 48091-2279 BIRMINGHAM MI 480097260	
33. BILLING PROVIDER INFO & PH # (24) 566 3313			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

PATIENT AND INSURED INFORMATION



FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 17J58079									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L										3. PATIENT'S BIRTH DATE 08151964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
5. PATIENT'S ADDRESS (No., Street) 1459 ANDREA STREET										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) 1459 ANDREA STREET										8. RESERVED FOR NUCC USE									
CITY YPSILANTI STATE MI										CITY YPSILANTI STATE MI									
ZIP CODE 48198 TELEPHONE (Include Area Code) (613) 718 4781										ZIP CODE 48198 TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MI PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10c. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefit is either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE										11. INSURED'S DATE OF BIRTH 08151964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.										15. OTHER DATE QUAL. MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR JEFFREY K WINGATE										16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 05102016 TO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO S CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. S CHARGES F. DAYS OR UNITS G. EPST/Ferry Fee H. I. ID. QUAL. J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. S CHARGES F. DAYS OR UNITS G. EPST/Ferry Fee H. I. ID. QUAL. J. RENDERING PROVIDER ID. #									
05102016 05102016 22 22612 78 AB 15948 00 1 NPI 1235117524										05102016 05102016 22 22612 78 AB 15948 00 1 NPI 1235117524									
05102016 05102016 22 22842 78 AB 7740 00 1 NPI 1235117524										05102016 05102016 22 22842 78 AB 7740 00 1 NPI 1235117524									
05102016 05102016 22 20680 78 AB 4050 00 1 NPI 1235117524										05102016 05102016 22 20680 78 AB 4050 00 1 NPI 1235117524									
05102016 05102016 22 38220 59,78 A 1485 00 1 NPI 1235117524										05102016 05102016 22 38220 59,78 A 1485 00 1 NPI 1235117524									
05102016 05102016 22 20936 78 A 1450 00 1 NPI 1235117524										05102016 05102016 22 20936 78 A 1450 00 1 NPI 1235117524									
05102016 05102016 22 20930 78 A 1100 00 1 NPI 1235117524										05102016 05102016 22 20930 78 A 1100 00 1 NPI 1235117524									
25. FEDERAL TAX ID NUMBER 462343653 SSN <input checked="" type="checkbox"/> EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. L4111									
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 31773 00									
29. AMOUNT PAID \$ 0 00										30. Revid for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) JEFFREY K WINGATE SIGNATURE ON FILE										32. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP SPINE PLLC 21230 DEQUINDRE ROAD WARREN MI 48091-2279									
33. BILLING PROVIDER INFO & PH # (248) 566 3313										34. BILLING PROVIDER INFO & PH # (248) 566 3313									
SIGNED 06012016										SIGNED 06012016									

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PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

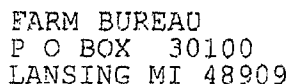


FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (NO#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 17J58079																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L										3. PATIENT'S BIRTH DATE 08151964										4. INSURED'S NAME (Last Name, First Name, Middle Initial) LITTLE, MAURICE, L									
5. PATIENT'S ADDRESS (No. Street) 1459 ANDREA STREET										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No. Street) 1459 ANDREA STREET									
8. RESERVED FOR NUCC USE										9. RESERVED FOR NUCC USE										10. RESERVED FOR NUCC USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. IS PATIENT'S CONDITION RELATED TO:										13. INSURED'S DATE OF BIRTH 08151964									
14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNATURE ON FILE										15. OTHER DATE 1134329493										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 05102016 TO 05102016									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JEFFREY K WINGATE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 05102016 TO 05102016										19. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										21. RESUBMISSION CODE										22. PRIOR AUTHORIZATION NUMBER									
23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From 05102016 To 05102016										25. FEDERAL TAX I.D. NUMBER 462343653									
26. TOTAL CHARGE 8000										27. AMOUNT PAID 000										28. Rsvd for NUCC Use									
29. BILLING PROVIDER INFO & PH # (248)566 3313										30. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP										31. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
32. SERVICE FACILITY LOCATION INFORMATION 21230 DEQUINDRE ROAD										33. BILLING PROVIDER INFO & PH # (248)566 3313										34. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
35. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										36. BILLING PROVIDER INFO & PH # (248)566 3313										37. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
38. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										39. BILLING PROVIDER INFO & PH # (248)566 3313										40. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
41. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										42. BILLING PROVIDER INFO & PH # (248)566 3313										43. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
44. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										45. BILLING PROVIDER INFO & PH # (248)566 3313										46. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
47. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										48. BILLING PROVIDER INFO & PH # (248)566 3313										49. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
50. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										51. BILLING PROVIDER INFO & PH # (248)566 3313										52. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
53. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										54. BILLING PROVIDER INFO & PH # (248)566 3313										55. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
56. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										57. BILLING PROVIDER INFO & PH # (248)566 3313										58. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
59. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										60. BILLING PROVIDER INFO & PH # (248)566 3313										61. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
62. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										63. BILLING PROVIDER INFO & PH # (248)566 3313										64. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
65. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										66. BILLING PROVIDER INFO & PH # (248)566 3313										67. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
68. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										69. BILLING PROVIDER INFO & PH # (248)566 3313										70. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
71. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										72. BILLING PROVIDER INFO & PH # (248)566 3313										73. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
74. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										75. BILLING PROVIDER INFO & PH # (248)566 3313										76. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
77. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										78. BILLING PROVIDER INFO & PH # (248)566 3313										79. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
80. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										81. BILLING PROVIDER INFO & PH # (248)566 3313										82. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
83. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										84. BILLING PROVIDER INFO & PH # (248)566 3313										85. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
86. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										87. BILLING PROVIDER INFO & PH # (248)566 3313										88. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
89. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										90. BILLING PROVIDER INFO & PH # (248)566 3313										91. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
92. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										93. BILLING PROVIDER INFO & PH # (248)566 3313										94. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
95. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										96. BILLING PROVIDER INFO & PH # (248)566 3313										97. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									
98. SERVICE FACILITY LOCATION INFORMATION WARREN MI 48091-2279										99. BILLING PROVIDER INFO & PH # (248)566 3313										100. SIGNATURE OF PHYSICIAN OR SUPPLIER JEFFREY K WINGATE									



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA									
1. MEDICARE MEDICAID TRICARE OHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare) (Medicaid) (ID#DoDr) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 17J58079									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L										3. PATIENT'S BIRTH DATE SEX 08151964 X F									
5. PATIENT'S ADDRESS (No. Street) 1459 ANDREA STREET										6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) LITTLE, MAURICE, L										7. INSURED'S ADDRESS (No. Street) 1459 ANDREA STREET									
CITY STATE YPSILANTI MI										CITY STATE YPSILANTI MI									
ZIP CODE TELEPHONE (Include Area Code) 48198 (313) 718 4781										ZIP CODE TELEPHONE (Include Area Code) 48198 ()									
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PAYMENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT (Current or Previous) YES NO X									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) X YES NO MI									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES NO X									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10a. CLAIM CODES (Designated by NUCC)									
e. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02142015 QUAL 431										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR JEFFREY K WINGATE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES NO X									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-1 to service line below (24E) A M5022 B C D										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. EPST: Family Plan I. IC. QUAL J. RENDERING PROVIDER ID. #										25. PRIOR AUTHORIZATION NUMBER									
10022015 10022015 11 99245 A 1200.00 1 NPI 1235117524																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use																			
462343653 X L4111 X YES NO \$ 1200.00 \$ 0.00																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JEFFREY K WINGATE SIGNATURE ON FILE										32. SERVICE FACILITY LOCATION INFORMATION SPINE PLLC 2151 EAST 14 MILE RD BIRMINGHAM MI 48009-7260									
SIGNED 04082016 31134329493										33. BILLING PROVIDER INFO & PH # SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260									

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC), 02/17

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
LITTLE MAURICE L		LITTLE, MAURICE, L	
3. PATIENT'S BIRTH DATE		7. INSURED'S ADDRESS (No. Street)	
08151964		1459 ANDREA STREET	
5. PATIENT'S ADDRESS (No. Street)		CITY	
1459 ANDREA STREET		YPSILANTI	
STATE		STATE	
MI		MI	
ZIP CODE		ZIP CODE	
48198		48198	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
(313) 718 4781		()	
8. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT (Current or Previous)		a. INSURED'S DATE OF BIRTH	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		08151964	
b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MI			
c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME		e. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)	
SIGNATURE ON FILE		SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
02142015		FROM MM DD YY TO MM DD YY	
QUAL 431			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
DR JEFFREY K WINGATE		FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L in service line below (2-4-E))		22. RESUBMISSION CODE	
A. M5022 B. M25559		ORIGINAL REF. NO.	
C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE		B. DAYS OF SERVICE	
From To		C. DAYS OF SERVICE	
MM DD YY MM DD YY		D. DAYS OF SERVICE	
12112015 12112015		1	
E. PLACE OF SERVICE		F. CHARGES	
G. SERVICE CODE		H. CHARGES	
I. CHARGES		J. CHARGES	
K. CHARGES		K. CHARGES	
L. CHARGES		L. CHARGES	
M. CHARGES		M. CHARGES	
N. CHARGES		N. CHARGES	
O. CHARGES		O. CHARGES	
P. CHARGES		P. CHARGES	
Q. CHARGES		Q. CHARGES	
R. CHARGES		R. CHARGES	
S. CHARGES		S. CHARGES	
T. CHARGES		T. CHARGES	
U. CHARGES		U. CHARGES	
V. CHARGES		V. CHARGES	
W. CHARGES		W. CHARGES	
X. CHARGES		X. CHARGES	
Y. CHARGES		Y. CHARGES	
Z. CHARGES		Z. CHARGES	
AA. CHARGES		AA. CHARGES	
AB. CHARGES		AB. CHARGES	
AC. CHARGES		AC. CHARGES	
AD. CHARGES		AD. CHARGES	
AE. CHARGES		AE. CHARGES	
AF. CHARGES		AF. CHARGES	
AG. CHARGES		AG. CHARGES	
AH. CHARGES		AH. CHARGES	
AI. CHARGES		AI. CHARGES	
AJ. CHARGES		AJ. CHARGES	
AK. CHARGES		AK. CHARGES	
AL. CHARGES		AL. CHARGES	
AM. CHARGES		AM. CHARGES	
AN. CHARGES		AN. CHARGES	
AO. CHARGES		AO. CHARGES	
AP. CHARGES		AP. CHARGES	
AQ. CHARGES		AQ. CHARGES	
AR. CHARGES		AR. CHARGES	
AS. CHARGES		AS. CHARGES	
AT. CHARGES		AT. CHARGES	
AU. CHARGES		AU. CHARGES	
AV. CHARGES		AV. CHARGES	
AW. CHARGES		AW. CHARGES	
AX. CHARGES		AX. CHARGES	
AY. CHARGES		AY. CHARGES	
AZ. CHARGES		AZ. CHARGES	
BA. CHARGES		BA. CHARGES	
BB. CHARGES		BB. CHARGES	
BC. CHARGES		BC. CHARGES	
BD. CHARGES		BD. CHARGES	
BE. CHARGES		BE. CHARGES	
BF. CHARGES		BF. CHARGES	
BG. CHARGES		BG. CHARGES	
BH. CHARGES		BH. CHARGES	
BI. CHARGES		BI. CHARGES	
BJ. CHARGES		BJ. CHARGES	
BK. CHARGES		BK. CHARGES	
BL. CHARGES		BL. CHARGES	
BM. CHARGES		BM. CHARGES	
BN. CHARGES		BN. CHARGES	
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18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon



FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC), 02/12

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		16. INSURED'S I.D. NUMBER (For Program In Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
LITTLE MAURICE L		08151964	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S ADDRESS (No. Street)	
LITTLE, MAURICE, L		1459 ANDREA STREET	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)	
Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		1459 ANDREA STREET	
8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYMENT (Current or Previous)	
b. RESERVED FOR NUCC USE		c. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		e. INSURED'S DATE OF BIRTH	
ADJ: SHERRIL KRAUSMAN		08151964	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
SIGNATURE ON FILE		SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)		15. OTHER DATE (MM/DD/YY)	
02142015 QUAL 431			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
DR JEFFREY K WINGATE		FROM MM/DD/YY TO MM/DD/YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Recode ALL to service the below (255))		22. RESUBMISSION CODE	
A. M5416 B. M5126 C. D. E.		ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE		25. PRIOR AUTHORIZATION NUMBER	
B. PLACE OF SERVICE			
C. PROCEDURE, SERVICE, OR SUPPLIES (Specify Dates or Circumstances)			
D. CHARGES			
E. DIAGNOSIS POINTER			
F. CHARGES			
G. DAYS OR UNITS			
H. REPT. FREQ.			
I. D QUAL			
J. RENDERING PROVIDER ID. #			
03222016 03222016 21 22633 A 1847700 1 NPI 1235117524			
03222016 03222016 21 63042 59,50 A 2606400 1 NPI 1235117524			
03222016 03222016 21 22830 AB 806400 1 NPI 1235117524			
03222016 03222016 21 22842 59 AB 774000 1 NPI 1235117524			
03222016 03222016 21 22852 59 AB 523600 1 NPI 1235117524			
03222016 03222016 21 22634 AB 1008000 2 NPI 1235117524			
26. FEDERAL TAX I.D. NUMBER		27. ACCEPT ASSIGNMENT?	
462343653		K YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. PATIENT'S ACCOUNT NO.		29. TOTAL CHARGE	
L4111		\$ 75661 00	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		31. AMOUNT PAID	
JEFFREY K WINGATE		\$ 0 00	
SIGNATURE ON FILE		32. BILLING PROVIDER INFO & PH #	
04082016		248 566 3313	
33. SERVICE FACILITY LOCATION INFORMATION		34. BILLING PROVIDER INFO & PH #	
S E MICHIGAN SURGICAL HOSP SPINE PLLC		248 566 3313	
21230 DEQUINDRE ROAD		2151 WEST 14 MILE	
WARREN MI 48091-2279		BIRMINGHAM MI 480097260	
35. SIGNATURE OF PHYSICIAN OR SUPPLIER		36. SIGNATURE OF PHYSICIAN OR SUPPLIER	
JEFFREY K WINGATE		JEFFREY K WINGATE	
SIGNATURE ON FILE		SIGNATURE ON FILE	
04082016		1134329493	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR081633

APPROVED OMB-0938-1197 FORM 1500 (02-12)

11/13/2018 10:48 AM Susan Dixon
WAYNE COUNTY CLERK
Cathy M. Garrett
FILED IN MY OFFICE
18-014385-CKFARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (TRICARE#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		PEGA <input checked="" type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1e. INSURED'S I.D. NUMBER (For Program in Item 1) 17J58079					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LITTLE MAURICE L						3. PATIENT'S BIRTH DATE 08151964		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) LITTLE, MAURICE, L									
5. PATIENT'S ADDRESS (No., Street) 1459 ANDREA STREET						6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1459 ANDREA STREET											
CITY YPSILANTI				STATE MI				CITY YPSILANTI				STATE MI							
ZIP CODE 48198				TELEPHONE (Include Area Code) (313) 718 4781				ZIP CODE 48198				TELEPHONE (Include Area Code) ()							
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR PEGA NUMBER							
9. OTHER INSURED'S POLICY OR GROUP NUMBER						12. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						13. INSURED'S DATE OF BIRTH MM DD YY 08151964							
14. RESERVED FOR NUCC USE						15. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MI						16. OTHER CLAIM ID (Designated by NUCC)							
17. RESERVED FOR NUCC USE						18. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						19. INSURANCE PLAN NAME OR PROGRAM NAME ADJ: SHERRIL KRAUSMAN							
20. INSURANCE PLAN NAME OR PROGRAM NAME						21. CLAIM CODES (Designated by NUCC)						22. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02142015												15. OTHER DATE MM DD YY QUAL 431				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR JEFFREY K WINGATE												17a. QUAL 17b. NP 1134329493				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				21. RESUBMISSION CODE ORIGINAL REF. NO.			
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A M5416 B M5126 C D E F G H I J K L												23. PRIOR AUTHORIZATION NUMBER				24. A DATE(S) OF SERVICE From To MM DD YY MM DD YY			
25. FEDERAL TAX I.D. NUMBER 462343653												26. PATIENT'S ACCOUNT NO. L4111				27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) JEFFREY K WINGATE SIGNATURE ON FILE												29. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279				30. BILLING PROVIDER INFO & PH # SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260			
31. DATE 04082016												32. DATE 1134329493				33. DATE 1134329493			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR061653

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input checked="" type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 17J58079																																																																																																									
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5. PATIENT'S ADDRESS (No., Street) 1459 ANDREA STREET						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 1459 ANDREA STREET																																																																																																											
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a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURED'S DATE OF BIRTH MM DD YY 08151964						SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																																					
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c. RESERVED FOR NUCC USE						d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME ADJ: SHERRIL KRAUSMAN						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																																																																																					
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services line below (24B)) A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.												22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																											
23. PRIOR AUTHORIZATION NUMBER																																																																																																																							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY												B. PLACE OF SERVICE BMC												C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT HCPCS MODIFIER												D. DIAGNOSIS POINTNER												E. S CHARGES												F. DAYS OR UNITS												G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.																																															
03222016 03222016												21												20930												A												110000												1												NPI												1235117524																																			
03222016 03222016												21												76000												26												A												8000												1												NPI												1235117524																							
25. FEDERAL TAX I.D. NUMBER 462343653												26. PATIENT'S ACCOUNT NO. L4111												27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 118000												29. AMOUNT PAID \$ 000												30. Revd for NUCC Use																																																											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof) JEFFREY K WINGATE SIGNATURE ON FILE												32. SERVICE FACILITY LOCATION INFORMATION S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279												33. BILLING PROVIDER INFO & PH # SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260																																																																																															
SIGNED 04082016												1750501938												1134329493																																																																																															

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

CR061653

APPROVED OMB-0938-1197 FORM 1500 (02-12)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 08-10-2009 BY 60322

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER	
(Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/>		(For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
1. LAST NAME: MAURICE, L		MM DD YY	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
1489 ANDREA STREET		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		STATE	
MPSILANTI		MI	
ZIP CODE		TELEPHONE (Include Area Code)	
48198		(313) 717 3147	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim, or to request payment of government benefits either to myself or to the party who accepts assignment below.)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNATURE ON FILE		a. INSURED'S DATE OF BIRTH	
SIGNED		MM DD YY	
DATE		SEX	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (M/P)		b. OTHER CLAIM ID (Designated by NUCC)	
MM DD YY		c. INSURANCE PLAN NAME OR PROGRAM NAME	
QUAL		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		SIGNATURE ON FILE	
17a. I		SIGNED	
17b. I/P		DATE	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-H to service line below (245))		FROM MM DD YY TO MM DD YY	
A. I		15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
B. I		FROM MM DD YY TO MM DD YY	
C. I		20. OUTSIDE LAB? \$ CHARGES	
D. I		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. I		22. RESUBMISSION CODE ORIGINAL REF. NO	
F. I		23. PRIOR AUTHORIZATION NUMBER	
G. I		24. A. DATES OF SERVICE	
H. I		From To	
I. I		MM DD YY MM DD YY	
J. I		B. PLACE OF SERVICE	
K. I		C. CPT/HCPCS	
L. I		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
M. I		E. DIAGNOSIS	
N. I		F. \$ CHARGES	
O. I		G. DAYS OR UNITS	
P. I		H. ICD-9	
Q. I		I. ID QUAL	
R. I		J. RENDERING PROVIDER ID. #	
S. I		25. FEDERAL TAX ID NUMBER	
T. I		SSN EIN	
U. I		26. PATIENT'S ACCOUNT NO.	
V. I		27. ACCEPT ASSIGNMENT?	
W. I		YES <input type="checkbox"/> NO <input type="checkbox"/>	
X. I		28. TOTAL CHARGE	
Y. I		29. AMOUNT PAID	
Z. I		30. Rsvd for NUCC Use	
AA. I		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS	
AB. I		32. SERVICE FACILITY LOCATION INFORMATION	
AC. I		33. BILLING PROVIDER INFO & PHONE	
AD. I		BIRMINGHAM MI 48009-260	
AE. I		1134329493	
AF. I		SIGNED	
AG. I		DATE	
AH. I		2.	
AI. I		3.	
AJ. I		4.	
AK. I		5.	
AL. I		6.	
AM. I		7.	
AN. I		8.	
AO. I		9.	
AP. I		10.	
AQ. I		11.	
AR. I		12.	
AS. I		13.	
AT. I		14.	
AU. I		15.	
AV. I		16.	
AW. I		17.	
AX. I		18.	
AY. I		19.	
AZ. I		20.	
BA. I		21.	
BB. I		22.	
BC. I		23.	
BD. I		24.	
BE. I		25.	
BF. I		26.	
BG. I		27.	
BH. I		28.	
BI. I		29.	
BJ. I		30.	
BK. I		31.	
BL. I		32.	
BM. I		33.	
BN. I		34.	
BO. I		35.	
BP. I		36.	
BQ. I		37.	
BR. I		38.	
BS. I		39.	
BT. I		40.	
BU. I		41.	
BV. I		42.	
BW. I		43.	
BX. I		44.	
BY. I		45.	
BZ. I		46.	
CA. I		47.	
CB. I		48.	
CC. I		49.	
CD. I		50.	
CE. I		51.	
CF. I		52.	
CG. I		53.	
CH. I		54.	
CI. I		55.	
CJ. I		56.	
CK. I		57.	
CL. I		58.	
CM. I		59.	
CN. I		60.	
CO. I		61.	
CP. I		62.	
CQ. I		63.	
CR. I		64.	
CS. I		65.	
CT. I		66.	
CU. I		67.	
CV. I		68.	
CW. I		69.	
CX. I		70.	
CY. I		71.	
CZ. I		72.	
DA. I		73.	
DB. I		74.	
DC. I		75.	
DD. I		76.	
DE. I			

APPROVED OMB-0938-1197 FORM 1500 (02-12)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (CHAMPVA) <input type="checkbox"/> GROUP HEALTH PLAN (Group Health Plan) <input type="checkbox"/> FECA BLKING (FECA BLKING) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		12. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM/DD/YY)		5. PATIENT'S RELATIONSHIP TO INSURED	
5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
6. CITY		8. CITY	
9. STATE		10. STATE	
11. ZIP CODE		12. ZIP CODE	
13. TELEPHONE (Include Area Code)		14. TELEPHONE (Include Area Code)	
15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		16. IS PATIENT'S CONDITION RELATED TO:	
17. IS PATIENT'S CONDITION RELATED TO:		18. INSURED'S POLICY GROUP OR FECA NUMBER	
19. INSURED'S DATE OF BIRTH (MM/DD/YY)		20. SEX	
21. OTHER CLAIM ID (Designated by NUCC)		22. INSURANCE PLAN NAME OR PROGRAM NAME	
23. IS THERE ANOTHER HEALTH BENEFIT PLAN?		24. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
25. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		26. SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
27. DATE		28. DATE	
29. DATE OF CURRENT ILLNESS INJURY, or PREGNANCY (MM/DD/YY)		30. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO)	
31. NAME OF REFERRING PROVIDER OR OTHER SOURCE		32. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)	
33. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		34. CHARGE LAB?	
35. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A to service line below (242))		36. CHARGES	
37. RESUBMIT ON CODE		38. ORIGINAL REF. NO.	
39. PRIOR AUTHORIZATION NUMBER		40. RENDERING PROVIDER ID. #	
41. A. DATE(S) OF SERVICE (From To)		42. B. PROCEDURE(S) SERVICES, OR SUPPLIES (Exclusion: Unusual Circumstances)	
43. C. PLACE OF SERVICE (EMG)		44. D. DIAGNOSIS (ICD-9)	
45. E. CHARGES		46. F. CHARGES	
47. G. DAYS ON UNITS		48. H. CHARGES	
49. I. CHARGES		50. J. CHARGES	
51. K. CHARGES		52. L. CHARGES	
53. M. CHARGES		54. N. CHARGES	
55. O. CHARGES		56. P. CHARGES	
57. Q. CHARGES		58. R. CHARGES	
59. S. CHARGES		60. T. CHARGES	
61. U. CHARGES		62. V. CHARGES	
63. W. CHARGES		64. X. CHARGES	
65. Y. CHARGES		66. Z. CHARGES	
67. AA. CHARGES		68. AB. CHARGES	
69. AC. CHARGES		70. AD. CHARGES	
71. AE. CHARGES		72. AF. CHARGES	
73. AG. CHARGES		74. AH. CHARGES	
75. AI. CHARGES		76. AJ. CHARGES	
77. AK. CHARGES		78. AL. CHARGES	
79. AM. CHARGES		80. AN. CHARGES	
81. AO. CHARGES		82. AP. CHARGES	
83. AQ. CHARGES		84. AR. CHARGES	
85. AS. CHARGES		86. AT. CHARGES	
87. AU. CHARGES		88. AV. CHARGES	
89. AW. CHARGES		90. AX. CHARGES	
91. AY. CHARGES		92. AZ. CHARGES	
93. BA. CHARGES		94. BB. CHARGES	
95. BC. CHARGES		96. BD. CHARGES	
97. BE. CHARGES		98. BF. CHARGES	
99. BG. CHARGES		100. BH. CHARGES	
101. BI. CHARGES		102. BJ. CHARGES	
103. BK. CHARGES		104. BL. CHARGES	
105. BM. CHARGES		106. BN. CHARGES	
107. BO. CHARGES		108. BP. CHARGES	
109. BQ. CHARGES		110. BR. CHARGES	
111. BS. CHARGES		112. BT. CHARGES	
113. BU. CHARGES		114. BV. CHARGES	
115. BW. CHARGES		116. BX. CHARGES	
117. BY. CHARGES		118. BZ. CHARGES	
119. CA. CHARGES		120. CB. CHARGES	
121. CC. CHARGES		122. CD. CHARGES	
123. CE. CHARGES		124. CF. CHARGES	
125. CG. CHARGES		126. CH. CHARGES	
127. CI. CHARGES		128. CJ. CHARGES	
129. CK. CHARGES		130. CL. CHARGES	
131. CM. CHARGES		132. CN. CHARGES	
133. CO. CHARGES		134. CP. CHARGES	
135. CQ. CHARGES		136. CR. CHARGES	
137. CS. CHARGES		138. CT. CHARGES	
139. CU. CHARGES		140. CV. CHARGES	
141. CW. CHARGES		142. CX. CHARGES	
143. CY. CHARGES		144. CZ. CHARGES	
145. DA. CHARGES		146. DB. CHARGES	
147. DC. CHARGES		148. DD. CHARGES	
149. DE. CHARGES		150. DF. CHARGES	
151. DG. CHARGES		152. DH. CHARGES	
153. DI. CHARGES		154. DJ. CHARGES	
155. DK. CHARGES		156. DL. CHARGES	
157. DM. CHARGES		158. DN. CHARGES	
159. DO. CHARGES		160. DP. CHARGES	
161. DQ. CHARGES		162. DR. CHARGES	
163. DS. CHARGES		164. DT. CHARGES	
165. DU. CHARGES		166. DV. CHARGES	
167. DW. CHARGES		168. DX. CHARGES	
169. DY. CHARGES		170. DZ. CHARGES	
171. EA. CHARGES		172. EB. CHARGES	
173. EC. CHARGES		174. ED. CHARGES	
175. EE. CHARGES		176. EF. CHARGES	
177. EG. CHARGES		178. EH. CHARGES	
179. EI. CHARGES		180. EJ. CHARGES	
181. EK. CHARGES		182. EL. CHARGES	
183. EM. CHARGES		184. EN. CHARGES	
185. EO. CHARGES		186. EP. CHARGES	
187. EQ. CHARGES		188. ER. CHARGES	
189. ES. CHARGES		190. ET. CHARGES	
191. EU. CHARGES		192. EV. CHARGES	
193. EW. CHARGES		194. EX. CHARGES	
195. EY. CHARGES		196. EZ. CHARGES	
197. FA. CHARGES		198. FB. CHARGES	
199. FC. CHARGES		200. FD. CHARGES	
201. FE. CHARGES		202. FF. CHARGES	
203. FG. CHARGES		204. FH. CHARGES	
205. FI. CHARGES		206. FJ. CHARGES	
207. FK. CHARGES		208. FL. CHARGES	
209. FM. CHARGES		210. FN. CHARGES	
211. FO. CHARGES		212. FP. CHARGES	
213. FQ. CHARGES		214. FR. CHARGES	
215. FS. CHARGES		216. FT. CHARGES	
217. FU. CHARGES		218. FV. CHARGES	
219. FW. CHARGES		220. FX. CHARGES	
221. FY. CHARGES		222. FZ. CHARGES	
223. GA. CHARGES		224. GB. CHARGES	
225. GC. CHARGES		226. GD. CHARGES	
227. GE. CHARGES		228. GF. CHARGES	
229. GG. CHARGES		230. GH. CHARGES	
231. GI. CHARGES		232. GJ. CHARGES	
233. GK. CHARGES		234. GL. CHARGES	
235. GM. CHARGES		236. GN. CHARGES	
237. GO. CHARGES		238. GP. CHARGES	
239. GQ. CHARGES		240. GR. CHARGES	
241. GS. CHARGES		242. GT. CHARGES	
243. GU. CHARGES		244. GV. CHARGES	
245. GW. CHARGES		246. GX. CHARGES	
247. GY. CHARGES		248. GZ. CHARGES	
249. HA. CHARGES		250. HB. CHARGES	
251. HC. CHARGES		252. HD. CHARGES	
253. HE. CHARGES		254. HF. CHARGES	
255. HG. CHARGES		256. HH. CHARGES	
257. HI. CHARGES		258. HJ. CHARGES	
259. HK. CHARGES		260. HL. CHARGES	
261. HM. CHARGES		262. HN. CHARGES	
263. HO. CHARGES		264. HP. CHARGES	
265. HQ. CHARGES		266. HR. CHARGES	
267. HS. CHARGES		268. HT. CHARGES	
269. HU. CHARGES		270. HV. CHARGES	
271. HW. CHARGES		272. HX. CHARGES	
273. HY. CHARGES		274. HZ. CHARGES	
275. IA. CHARGES		276. IB. CHARGES	
277. IC. CHARGES		278. ID. CHARGES	
279. IE. CHARGES		280. IF. CHARGES	
281. IG. CHARGES		282. IH. CHARGES	
283. II. CHARGES		284. IJ. CHARGES	
285. IK. CHARGES		286. IL. CHARGES	
287. IM. CHARGES		288. IN. CHARGES	
289. IO. CHARGES		290. IP. CHARGES	
291. IQ. CHARGES		292. IR. CHARGES	
293. IS. CHARGES		294. IT. CHARGES	
295. IU. CHARGES		296. IV. CHARGES	
297. IW. CHARGES		298. IX. CHARGES	
299. IY. CHARGES		300. IZ. CHARGES	
301. JA. CHARGES		302. JB. CHARGES	
303. JC. CHARGES		304. JD. CHARGES	
305. JE. CHARGES		306. JF. CHARGES	
307. JG. CHARGES		308. JH. CHARGES	
309. JI. CHARGES		310. JJ. CHARGES	
311. JK. CHARGES		312. JL. CHARGES	
313. JM. CHARGES		314. JN. CHARGES	
315. JO. CHARGES		316. JP. CHARGES	
317. JQ. CHARGES		318. JR. CHARGES	
319. JS. CHARGES		320. JT. CHARGES	
321. JU. CHARGES		322. JV. CHARGES	
323. JW. CHARGES		324. JX. CHARGES	
325. JY. CHARGES		326. JZ. CHARGES	
327. KA. CHARGES		328. KB. CHARGES	
329. KC. CHARGES		330. KD. CHARGES	
331. KE. CHARGES		332. KF. CHARGES	
333. KG. CHARGES		334. KH. CHARGES	
335. KI. CHARGES		336. KJ. CHARGES	
337. KK. CHARGES		338. KL. CHARGES	
339. KM. CHARGES		340. KN. CHARGES	
341. KO. CHARGES		342. KP. CHARGES	
343. KQ. CHARGES		344. KR. CHARGES	
345. KS. CHARGES		346. KT. CHARGES	
347. KU. CHARGES		348. KV. CHARGES	
349. KW. CHARGES		350. KX. CHARGES	
351. KY. CHARGES		352. KZ. CHARGES	
353. LA. CHARGES		354. LB. CHARGES	
355. LC. CHARGES		356. LD. CHARGES	
357. LE. CHARGES		358. LF. CHARGES	
359. LG. CHARGES		360. LH. CHARGES	
361. LI. CHARGES		362. LJ. CHARGES	
363. LK. CHARGES		364. LL. CHARGES	
365. LM. CHARGES		366. LN. CHARGES	
367. LO. CHARGES		368. LP. CHARGES	
369. LQ. CHARGES		370. LR. CHARGES	
371. LS. CHARGES		372. LT. CHARGES	
373. LU. CHARGES		374. LV. CHARGES	
375. LW. CHARGES		376. LX. CHARGES	
377. LY. CHARGES		378. LZ. CHARGES	
379. MA. CHARGES		380. MB. CHARGES	
381. MC. CHARGES		382. MD. CHARGES	
383. ME. CHARGES		384. MF. CHARGES	
385. MG. CHARGES		386. MH. CHARGES	
387. MI. CHARGES		388. MJ. CHARGES	
389. MK. CHARGES		390. ML. CHARGES	
391. MM. CHARGES		392. MN. CHARGES	
393. MO. CHARGES		394. MP. CHARGES	
395. MQ. CHARGES		396. MR. CHARGES	
397. MS. CHARGES		398. MT. CHARGES	
399. MU. CHARGES		400. MV. CHARGES	
401. MW. CHARGES		402. MX. CHARGES	
403. MY. CHARGES		404. MZ. CHARGES	
405. NA. CHARGES		406. NB. CHARGES	
407. NC. CHARGES		408. ND. CHARGES	
409. NE. CHARGES		410. NF. CHARGES	
411. NG. CHARGES		412. NH. CHARGES	
413. NI. CHARGES		414. NJ. CHARGES	
415. NK. CHARGES		416. NL. CHARGES	
417. NM. CHARGES		418. NN. CHARGES	
419. NO. CHARGES		420. NP. CHARGES	
421. NQ. CHARGES		422. NR. CHARGES	
423. NS. CHARGES		424. NT. CHARGES	
425. NU. CHARGES		426. NV. CHARGES	
427. NW. CHARGES		428. NX. CHARGES	
429. NY. CHARGES		430. NZ. CHARGES	
431. OA. CHARGES		432. OB. CHARGES	
433. OC. CHARGES		434. OD. CHARGES	
435. OE. CHARGES		436. OF. CHARGES	
437. OG. CHARGES		438. OH. CHARGES	
439. OI. CHARGES		440. OJ. CHARGES	
441. OK. CHARGES		442. OL. CHARGES	
443. OM. CHARGES		444. ON. CHARGES	
445. OO. CHARGES		446. OP. CHARGES	
447. OQ. CHARGES		448. OR. CHARGES	
449. OS. CHARGES		450. OT. CHARGES	
451. OU. CHARGES		452. OV. CHARGES	
453. OW. CHARGES		454. OX. CHARGES	
455. OY. CHARGES		456. OZ. CHARGES	
457. PA. CHARGES		458. PB. CHARGES	
459. PC. CHARGES		460. PD. CHARGES	
461. PE. CHARGES		462. PF. CHARGES	
463. PG. CHARGES		464. PH. CHARGES	
465. PI. CHARGES		466. PJ. CHARGES	
467. PK. CHARGES		468. PL. CHARGES	
469. PM. CHARGES		470. PN. CHARGES	
471. PO. CHARGES		472. PP. CHARGES	
473. PQ. CHARGES		474. PR. CHARGES	
475. PS. CHARGES		476. PT. CHARGES	
477. PU. CHARGES		478. PV. CHARGES	
479. PW. CHARGES		480. PX. CHARGES	
481. PY. CHARGES		482. PZ. CHARGES	
483. QA. CHARGES		484. QB. CHARGES	
485. QC. CHARGES		486. QD. CHARGES	
487. QE. CHARGES		488. QF. CHARGES	
489. QG. CHARGES		490. QH. CHARGES	
491. QI. CHARGES		492. QJ. CHARGES	
493. QK. CHARGES		494. QL. CHARGES	
495. QM. CHARGES		496. QN. CHARGES	
497. QO. CHARGES		498. QP. CHARGES	
499. QQ. CHARGES		500. QR. CHARGES	
501. QS. CHARGES		502. QT. CHARGES	
503. QU. CHARGES		504. QV. CHARGES	
505. QW. CHARGES		506. QX. CHARGES	
507. QY. CHARGES		508. QZ. CHARGES	
509. RA. CHARGES		510. RB. CHARGES	
511. RC. CHARGES		512. RD. CHARGES	
513. RE. CHARGES		514. RF. CHARGES	
515. RG. CHARGES		516. RH. CHARGES	
517. RI. CHARGES		518. RJ. CHARGES	
519. RK. CHARGES		520. RL. CHARGES	
521. RM. CHARGES		522. RN. CHARGES	
523. RO. CHARGES		524. RP. CHARGES	
525. RQ. CHARGES		526. RR. CHARGES	
527. RS. CHARGES		528. RT. CHARGES	
529. RU. CHARGES		530. RV. CHARGES	
531. RW. CHARGES		532. RX. CHARGES	
533. RY. CHARGES		534. RZ. CHARGES	
535. SA. CHARGES		536. SB. CHARGES	
537. SC. CHARGES		538. SD. CHARGES	
539. SE. CHARGES		540. SF. CHARGES	
541. SG. CHARGES		542. SH. CHARGES	
543. SI. CHARGES		544. SJ. CHARGES	
545. SK. CHARGES		546. SL. CHARGES	
547. SM. CHARGES		548. SN. CHARGES	
549. SO. CHARGES			

Exhibit 3C

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Report Date: 4/11/2018

SUMMIT MEDICAL GROUP PLLC

Page: 1

Patient Visit Report - From 05/09/2016 To 05/09/2017 - Office: -- All -- - Provider: Won Chae, MD - Insurance: All -
 Patient ID: 56235052

Date of Service	POS	CPT	A	B	C	D	Days or Units	Charges	Insurance Payment	Patient Payment	Adj.	Balance	
Patient: LITTLE, MAURICE				Patient ID: 56235052				Sex: M		DOB: 8/15/1964			
Insurance: Farm Bureau				Provider: Won Chae, MD				Office:					
6/29/2016	11	73502		RT			1	\$140.00	\$0.00	\$0.00	\$0.00	\$140.00	
Sub Total:								\$140.00	\$0.00	\$0.00	\$0.00	\$140.00	
Patient: LITTLE, MAURICE				Patient ID: 56235052				Sex: M		DOB: 8/15/1964			
Insurance: Farm Bureau				Provider: Won Chae, MD				Office:					
7/17/2016	11	72100					1	\$130.00	\$0.00	\$0.00	\$0.00	\$130.00	
Sub Total:								\$130.00	\$0.00	\$0.00	\$0.00	\$130.00	
Patient Count: 1								Report Total:	\$270.00	\$0.00	\$0.00	\$0.00	\$270.00

Exhibit 3D

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

SUMMIT MEDICAL GROUP

Individual Patient Balance Form

Release date through

04/11/18

Name:

Maurice Little

Date of Birth:

08/15/64

Department Balances (By Taxpayer Identification Number)

TIN:	Department:	Balance:
80058968	SMG- Dr. Jankowski	\$117,219.00
	SMG- Dr. Jankowski Rx	\$3,821.50
	Summit Medical Group - TOTAL	\$121,040.50
80058968	SMG-Physical Therapy	\$4,700.00
COMBINED TOTAL (From All Tax Entities):		\$138,306.50

*Please request all billing ledgers from SMG Lead Contacts 48 hours prior to all settlement conferences.

*Balances may change all the time as treatment may be ongoing.

*Please notify lead contacts ASAP if future benefits are going to be released.

SMG Lead Contacts

Name	Contact Details:
T. Weaver	(Phone) 313.581.3255 (Fax) 313.581.3755 (Email) tweaver@summitgroupmd.com
L. Maracle	(Phone) 313.334.388 (Fax) 313.334.4318 (Email) lmaracle@summitgroupmd.com

Exhibit 3E

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Statement Date

May 4, 2015

Getter Done Medical Transportation L.L.C
P.O. Box 862
Dearborn Heights, MI 48127
T: (248) 430-4831 F: (248) 430-4832

EIN: 27-4539683
Claim No.: 0001522918

To Whom It May Concern:
Re: Maurice Little
Enclosed is the medical transportation billing.

DOS	Pick-up Location	Drop-off Location	Mileage	Charge	Round Trip	Type of Visit
03-04-15	1459 Andrea Ypsilanti, MI 48198	8580 N Silvery Ln Dearborn Heights, MI 48127	48	\$150.00	YES	MRI
03-11-15	1459 Andrea Ypsilanti, MI 48198	1678 Merriam Rd Westland, MI 48186	34	\$95.00	YES	Dr. Lemer
03-13-15	1459 Andrea Ypsilanti, MI 48198	1678 Merriam Rd Westland, MI 48186	34	\$95.00	YES	Dr. Lemer

Additional drop off location(s) is an additional charge of \$32.50

- \$65.00 Flat rate (0.1 Miles – 20 Miles)
- \$95.00 Flat Rate (21Miles – 45 Miles)
- \$150.00 Flat Rate (46Miles – Up to 75 Miles)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Statement Date	Inv. #
4/13/2016	413163

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
5/29/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/3/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/5/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/8/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/10/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Office Visit	NEW - 413163
6/12/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/15/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/17/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	\$95.00	YES	Physical Therapy	NEW - 413163
6/22/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
6/22/15	1678 Merriman Rd., Westland, MI 48186	27207 Lahser Southfield, MI 48034	18.2	\$32.50	NO	Physical Therapy	NEW - 413163
6/22/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	14.9	\$32.50	NO	Physical Therapy	NEW - 413163

6/25/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
6/29/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
6/30/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/6/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/7/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	49	\$150.00	YES	MRI	NEW - 413163
7/8/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/9/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	24.5	\$95.00	NO	Office Visit	NEW - 413163
7/9/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	27207 Lahser Southfield, MI 48034	10.9	\$32.50	NO	Physical Therapy	NEW - 413163
7/10/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	49	\$150.00	YES	MRI	NEW - 413163
7/13/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/14/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
7/14/15	27207 Lahser Southfield, MI 48034	8560 N. Silvery Lane, Dearborn Heights, MI 48127	10.9	\$32.50	NO	Office Visit	NEW - 413163
7/14/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	1459 Andrea St., Ypsilanti, MI 48198	24.5	\$95.00	NO	Office Visit	NEW - 413163
7/15/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/20/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/22/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/23/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163

7/27/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/28/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/29/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
7/31/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
8/5/15	1459 Andrea St., Ypsilanti, MI 48198	26025 Lahser Rd., Southfield, MI 48033	66.8	\$150.00	YES	Office Visit	NEW - 413163
9/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/8/15	33000 Annapolis Ave., Wayne, MI 48184	27207 Lahser Southfield, MI 48034	23	\$95.00	NO	Physical Therapy	NEW - 413163
9/8/15	1459 Andrea St., Ypsilanti, MI 48198	33000 Annapolis Ave., Wayne, MI 48184	14	\$32.50	NO	Office Visit	NEW - 413163
9/8/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
9/11/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/18/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/21/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/22/15	1459 Andrea St., Ypsilanti, MI 48198	18101 Oakwood, Dearborn, MI 48124	44.2	\$95.00	YES	CT Scan	NEW - 413163
9/23/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/25/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
9/29/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
9/29/15	33000 Annapolis Ave., Wayne, MI 48184	27207 Lahser Southfield, MI 48034	23	\$95.00	NO	Physical Therapy	NEW - 413163
9/29/15	1459 Andrea St., Ypsilanti, MI 48198	33000 Annapolis Ave., Wayne, MI 48184	14	\$32.50	NO	Office Visit	NEW - 413163

9/30/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
10/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
10/2/15	27207 Lahser Southfield, MI 48034	8560 N. Silvery Lane, Dearborn Heights, MI 48127	10.9	\$32.50	NO	Office Visit	NEW - 413163
10/2/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	1459 Andrea St., Ypsilanti, MI 48198	24.5	\$95.00	NO	Physical Therapy	NEW - 413163
10/5/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	27207 Lahser Southfield, MI 48034	10.9	\$32.50	NO	Physical Therapy	NEW - 413163
10/5/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	24.5	\$95.00	NO	Office Visit	NEW - 413163
10/5/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	\$95.00	NO	Physical Therapy	NEW - 413163
10/7/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	\$150.00	YES	Physical Therapy	NEW - 413163
2/19/16	41472 Archwood, Belleville, MI 48111	8560 N. Silvery Lane, Dearborn Heights, MI 48127	35	\$95.00	YES	Office Visit	NEW - 413163

Total New Billing:	\$6,250.00
Total Previous Billing:	\$0.00
Total Amount Outstanding:	\$6,250.00

Additional drop off location(s) is an additional charge of \$32.50

- \$65.00 Flat Rate (0.1 Miles - 20 Miles)
- \$95.00 Flat Rate (21 Miles - 45 Miles)
- \$150.00 Flat Rate (46 Miles - Up to 75 Miles)

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

Statement Date	Inv. #
5/25/2016	525165

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
03/11/16	1459 Andrea St, Ypsilanti, MI 48198	8560 N Silvery Ln, Dearborn Heights, MI 48127	49	\$150.00	YES	MRI	525165

Total New Billing:	\$150.00
Total Previous Billing:	\$6,250.00
Total Amount Outstanding:	\$6,400.00

Additional drop off location(s) is an additional charge of \$32.50

- \$65.00 Flat Rate (0.1 Miles - 20 Miles)
- \$95.00 Flat Rate (21 Miles - 45 Miles)
- \$150.00 Flat Rate (46 Miles - Up to 75 Miles)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Statement Date	Inv. #
1/10/2017	110171

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
07/14/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	\$95.00	YES	PHYS THERAPY	110171
07/18/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	\$95.00	YES	PHYS THERAPY	110171
07/26/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	\$95.00	YES	PHYS THERAPY	110171
07/28/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	\$95.00	YES	PHYS THERAPY	110171
08/23/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	\$95.00	YES	PHYS THERAPY	110171

Total New Billing:	\$475.00
Total Previous Billing:	\$6,400.00
Total Amount Outstanding:	\$6,875.00

Additional drop off location(s) is an additional charge of \$32.50

- \$65.00 Flat Rate (0.1 Miles - 20 Miles)
- \$95.00 Flat Rate (21 Miles - 45 Miles)
- \$150.00 Flat Rate (46 Miles - Up to 75 Miles)

001073

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Statement Date	Inv. #
5/7/2017	507172

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27-4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
08/23/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne MI 48184	28	\$150.00	YES	Office Visit	507172
11/22/16	33000 Annapolis Ave, Wayne MI 48184	1459 Andrea St, Ypsilanti, MI 48198	14	\$90.00	NO	Office Visit	507172

Total New Billing:	\$240.00
Total Previous Billing:	\$6,400.00
Total Amount Outstanding:	\$6,640.00

Additional drop off location(s) is an additional charge of \$45.00

- \$90.00 Flat Rate (0.1 Miles - 20 Miles)
- \$150.00 Flat Rate (21 Miles - 45 Miles)
- \$210.00 Flat Rate (46 Miles - Up to 75 Miles)

Exhibit 3F

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

Transaction Search Results

Page 1 of 3

Account: MAURICE LITTLE, 396119						Demographics Transactions Comments	
P Bal	I Bal	W Bal	C Bal	Total		New Search	Cancel Help
<u>.00</u>	<u>.00</u>	<u>.00</u>	<u>.00</u>	<u>.00</u>			

Search criteria: CRA; Account: 396119; All; Payer Status: All; Pymt Status: All; Detail; Sort by: Date of Service, Ascending; Separate Open and Paid; Exclude Corrections, ATR0;

Change Search

Transactions

Charge #	Date	Patient	Prov	POS	Trans/Mod	Pri Dx	Amount	P/A Total	Due	Due From
<u>343654</u>	09/08/2015	MAURICE	KCL	OFF	73510	71595	140.00	<u>140.00</u>	.00	FAR7/IO
Adj	09/08/2015				ATTY			140.00		
<u>343658</u>	09/08/2015	MAURICE	KCL	OFF	99243	71595	500.00	<u>500.00</u>	.00	FAR7/IO
Adj	09/08/2015				ATTY			500.00		
<u>343652</u>	09/29/2015	MAURICE	KCL	OFF	99213	71595	250.00	<u>250.00</u>	.00	FAR7/IO
Adj	09/29/2015				ATTY			250.00		
<u>343655</u>	10/21/2015	MAURICE	KCL	ANNOP	27130/RT	71525/M166	4980.00	<u>4980.00</u>	.00	FAR7/IO
Adj	10/21/2015				ATTY			4980.00		
<u>343657</u>	10/28/2015	MAURICE	KCL	OFF	97110	71945/M25551	110.00	<u>110.00</u>	.00	FAR7/IO
Adj	10/28/2015				ATTY			110.00		
<u>343659</u>	10/28/2015	MAURICE	KCL	OFF	97001	71945/M25551	260.00	<u>260.00</u>	.00	FAR7/IO
Adj	10/28/2015				ATTY			260.00		
<u>343660</u>	10/28/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00	FAR7/IO
Adj	10/28/2015				ATTY			75.00		
<u>343661</u>	10/28/2015	MAURICE	KCL	OFF	97010	71945/M25551	40.00	<u>40.00</u>	.00	FAR7/IO
Adj	10/28/2015				ATTY			40.00		
<u>343662</u>	11/02/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	<u>220.00</u>	.00	WSTI/IO
Adj	11/02/2015				ATTY			220.00		
<u>343663</u>	11/02/2015	MAURICE	KCL	OFF	97140	71945/M25551	220.00	<u>220.00</u>	.00	FAR7/IO
Adj	11/02/2015				ATTY			220.00		
<u>343664</u>	11/02/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00	WSTI/IO
Adj	11/02/2015				ATTY			75.00		
<u>344746</u>	11/03/2015	MAURICE	KCL	OFF	99024/NC	71525/M166	.00	.00	.00	FAR7/IO
<u>344747</u>	11/03/2015	MAURICE	KCL	OFF	73510	71525/M166	140.00	<u>140.00</u>	.00	FAR7/IO
Adj	11/03/2015				ATTY			140.00		
<u>343665</u>	11/06/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	<u>220.00</u>	.00	WSTI/IO
Adj	11/06/2015				ATTY			220.00		
<u>343666</u>	11/06/2015	MAURICE	KCL	OFF	97140	71945/M25551	110.00	<u>110.00</u>	.00	FAR7/IO
Adj	11/06/2015				ATTY			110.00		
<u>343667</u>	11/06/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00	FAR7/IO
Adj	11/06/2015				ATTY			75.00		
<u>343668</u>	11/06/2015	MAURICE	KCL	OFF	97010	71945/M25551	40.00	<u>40.00</u>	.00	FAR7/IO
Adj	11/06/2015				ATTY			40.00		
<u>343669</u>	11/09/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	<u>220.00</u>	.00	WSTI/IO
Adj	11/09/2015				ATTY			220.00		

Transaction Search Results

Page 2 of 3

<u>343670</u>	11/09/2015	MAURICE KCL	OFF	97140	71945/M25551	220.00	<u>220.00</u>	.00 FAR7/IO
Adj	11/09/2015			ATTY			220.00	
<u>343671</u>	11/09/2015	MAURICE KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00 FAR7/IO
Adj	11/09/2015			ATTY			75.00	
<u>343672</u>	11/11/2015	MAURICE KCL	OFF	97110	71945/M25551	220.00	<u>220.00</u>	.00 FAR7/IO
Adj	11/11/2015			ATTY			220.00	
<u>343673</u>	11/11/2015	MAURICE KCL	OFF	97140	71945/M25551	220.00	<u>220.00</u>	.00 FAR7/IO
Adj	11/11/2015			ATTY			220.00	
<u>343674</u>	11/11/2015	MAURICE KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00 FAR7/IO
Adj	11/11/2015			ATTY			75.00	
<u>343675</u>	11/16/2015	MAURICE KCL	OFF	97110	71945/M25551	110.00	<u>110.00</u>	.00 WSTI/IO
Adj	11/16/2015			ATTY			110.00	
<u>343676</u>	11/16/2015	MAURICE KCL	OFF	97140	71945/M25551	110.00	<u>110.00</u>	.00 WSTI/IO
Adj	11/16/2015			ATTY			110.00	
<u>343677</u>	11/16/2015	MAURICE KCL	OFF	97112	71945/M25551	120.00	<u>120.00</u>	.00 FAR7/IO
Adj	11/16/2015			ATTY			120.00	
<u>343678</u>	11/16/2015	MAURICE KCL	OFF	97014	71945/M25551	75.00	<u>75.00</u>	.00 FAR7/IO
Adj	11/16/2015			ATTY			75.00	
<u>343679</u>	11/16/2015	MAURICE KCL	OFF	97010	71945/M25551	40.00	<u>40.00</u>	.00 FAR7/IO
Adj	11/16/2015			ATTY			40.00	
<u>341494</u>	11/17/2015	MAURICE KCS	OFF	99024/NC	71525/M166	.00	.00	.00 WSTI/IO
<u>344756</u>	12/03/2015	MAURICE KCL	OFF	99213	71945/M25551	250.00	<u>250.00</u>	.00 FAR7/IO
Adj	12/03/2015			ATTY			250.00	
<u>344757</u>	12/03/2015	MAURICE KCL	OFF	73510	71945/M25551	140.00	<u>140.00</u>	.00 FAR7/IO
Adj	12/03/2015			ATTY			140.00	
<u>343322</u>	12/21/2015	MAURICE KCL	SIMI	27134/78RT	72810/M619	6630.00	<u>6630.00</u>	.00 FAR7/IO
Adj	12/21/2015			ATTY			6630.00	
<u>343323</u>	12/21/2015	MAURICE KCL	SIMI	27062/7859	72810/M619	1510.00	<u>1510.00</u>	.00 FAR7/IO
Adj	12/21/2015			ATTY			1510.00	
<u>347094</u>	01/19/2016	MAURICE KCL	OFF	99024/NC	71525/M166	.00	.00	.00 FAR7/IO
<u>347095</u>	01/19/2016	MAURICE KCL	OFF	73502/RT	71525/M166	140.00	<u>140.00</u>	.00 FAR7/IO
Adj	01/19/2016			ATTY			140.00	
<u>347252</u>	02/23/2016	MAURICE KCL	OFF	99213/25	71945/M25551	250.00	<u>250.00</u>	.00 FAR7/IO
Adj	02/23/2016			ATTY			250.00	
<u>347253</u>	02/23/2016	MAURICE KCL	OFF	73565	71945/M25551	130.00	<u>130.00</u>	.00 FAR7/IO
Adj	02/23/2016			ATTY			130.00	
<u>347254</u>	02/23/2016	MAURICE KCL	OFF	20611/RT	71945/M25551	900.00	<u>900.00</u>	.00 FAR7/IO
Adj	02/23/2016			ATTY			900.00	
<u>347255</u>	02/23/2016	MAURICE KCL	OFF	J0702	71945/M25551	70.00	<u>70.00</u>	.00 FAR7/IO
Adj	02/23/2016			ATTY			70.00	
<u>347256</u>	02/23/2016	MAURICE KCL	OFF	73502/RT	7177/M2241	140.00	<u>140.00</u>	.00 FAR7/IO
Adj	02/23/2016			ATTY			140.00	
<u>348953</u>	03/08/2016	MAURICE KCL	OFF	99213	7177/M2241	250.00	<u>250.00</u>	.00 FAR7/IO
Adj	03/08/2016			ATTY			250.00	
<u>349255</u>	03/17/2016	MAURICE KCL	OFF	99213	71946/M25561	250.00	<u>250.00</u>	.00 FAR7/IO

Transaction Search Results

Page 3 of 3

Adj 03/17/2016 ATTY 250.00
 352499 04/26/2016 MAURICE KCL OFF 99214 71946/M25562 370.00 370.00 .00 FAR7/IO
 Adj 04/26/2016 ATTY 370.00
 352500 04/26/2016 MAURICE KCL OFF 73502/RT 71945/M25551 140.00 140.00 .00 FAR7/IO
 Adj 04/26/2016 ATTY 140.00
 352501 04/26/2016 MAURICE KCL OFF 73560/RT 71946/M25562 110.00 110.00 .00 FAR7/IO
 Adj 04/26/2016 ATTY 110.00
 352502 04/26/2016 MAURICE KCL OFF 73560/LT 71946/M25562 110.00 110.00 .00 FAR7/IO
 Adj 04/26/2016 ATTY 110.00

 354117 05/17/2016 MAURICE CLT OFF 99213 71946/M25561 250.00 250.00 .00 FAR7/IO
 Adj 05/17/2016 ATTY 250.00
 355431 06/16/2016 MAURICE CLT OFF 99213 71946/M25561 250.00 250.00 .00 FAR7/IO
 Adj 06/16/2016 ATTY 250.00
 355432 06/16/2016 MAURICE CLT OFF 73502/RT 72810/M619 140.00 140.00 .00 FAR7/IO
 Adj 06/16/2016 ATTY 140.00
 356610 07/07/2016 MAURICE CLT OFF 99213 71525/M166 250.00 250.00 .00 FAR7/IO
 Adj 07/07/2016 ATTY 250.00
 357056 07/12/2016 MAURICE SLT OFF 97001 71945/M25551 260.00 260.00 .00 FAR7/IO
 Adj 07/20/2016 ATTY 260.00
 357057 07/12/2016 MAURICE SLT OFF 97110 71945/M25551 110.00 110.00 .00 FAR7/IO
 Adj 07/20/2016 ATTY 110.00
 357058 07/14/2016 MAURICE SLT OFF 97110 71945/M25551 220.00 220.00 .00 FAR7/IO
 Adj 07/20/2016 ATTY 220.00
 357059 07/14/2016 MAURICE SLT OFF 97140 71945/M25551 220.00 220.00 .00 FAR7/IO
 Adj 07/20/2016 ATTY 220.00
 357060 07/14/2016 MAURICE SLT OFF 97014 71945/M25551 75.00 75.00 .00 FAR7/IO
 Adj 07/20/2016 ATTY 75.00
 357719 07/18/2016 MAURICE CLT OFF 97110 71945/M25551 220.00 220.00 .00 FAR7/IO
 Adj 07/18/2016 ATTY 220.00
 357720 07/18/2016 MAURICE CLT OFF 97140 71945/M25551 110.00 110.00 .00 FAR7/IO
 Adj 07/18/2016 ATTY 110.00
 357721 07/18/2016 MAURICE CLT OFF G0283 71945/M25551 75.00 75.00 .00 FAR7/IO
 Adj 07/18/2016 ATTY 75.00
 358019 07/26/2016 MAURICE CLT OFF 97110 71945/M25551 220.00 220.00 .00 FAR7/IO
 Adj 07/26/2016 ATTY 220.00
 358020 07/26/2016 MAURICE CLT OFF 97140 71945/M25551 110.00 110.00 .00 FAR7/IO
 Adj 07/26/2016 ATTY 110.00
 358021 07/26/2016 MAURICE CLT OFF 97014 71945/M25551 75.00 75.00 .00 FAR7/IO
 Adj 07/26/2016 ATTY 75.00
 358329 07/28/2016 MAURICE CLT OFF 99213 71525/M166 250.00 250.00 .00 FAR7/IO
 Adj 07/28/2016 ATTY 250.00
Totals 23165.00 23165.00 .00

62 matches found

Kevin T Crawford, D.O., PC
Patient Procedure Summary
 MAURICE LITTLE (14461)

DOS	Description	Expected	Charges	Adjust	Receipts	Pat. Balance	Ins. Balance	Total Balance
08/11/2016	MAURICE LITTLE 99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
09/23/2016	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
09/23/2016	E0747 - Elec osteogen slim not spine	-	6,500.00	-	-	-	6,500.00	6,500.00
11/22/2016	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
11/22/2016	73560 - RADIOLOGIC EXAM, KNEE; 1/2 VIEWS	-	110.00	-	-	-	110.00	110.00
11/22/2016	73565 - RADIOLOGIC EXAM, KNEE; BOTH KNEES, STANDING, ANTEROPOSTERIOR	-	130.00	-	-	-	130.00	130.00
11/22/2016	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: DETAILED HX; DETAILED EXAM; MED DECISION MOD COMPLEXITY	-	370.00	-	-	-	370.00	370.00
11/22/2016	L1833 - Ko adj jnt pos r sup pre ois	-	950.00	-	-	-	950.00	950.00
07/13/2017	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
07/13/2017	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
08/17/2017	72170 - RADIOLOGIC EXAM, PELVIS; 1 OR 2 VIEWS	-	100.00	-	-	-	100.00	100.00
08/17/2017	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
03/06/2018	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
03/13/2018	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
		-	9,830.00	-	-	-	9,830.00	9,830.00

SPG - \$20,429
 DOPC - \$12,566
\$32,995

4/11/2018 10:19:18 AM

Page 1 of 1